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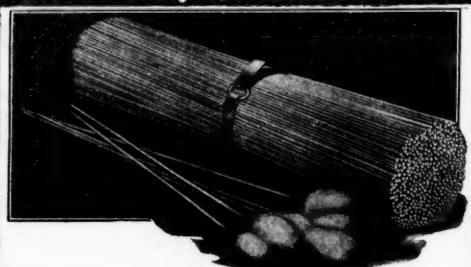
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## ORIGINAL ARTICLES

### "MODERN ITALIAN SURGERY."\*

By JOHN W. KEEFE, M.D.

PROVIDENCE, R. I.

Two voyages to Italy, one some seventeen years ago and the other about a year since, with a study of Roman history and of the lives of many of the great scholars, artists and heroes who have dwelt in that sunny clime, led me to enlarge upon some of my impressions, which I shall present to you today.

While many of us realize that travel is a most enjoyable method of acquiring useful knowledge and of broadening one's horizon; there is too great a tendency for most of us to defer our journey to some opportune time, and too often this ideal time never arrives.

We may read the works of noted teachers of medicine and undoubtedly they have value; but if we have had the opportunity to come in close contact with a man, hear him teach and see him operate in his home clinic, where he does his best work; we then may come away with some part of his magnetism, which has entered our souls and helps keep the fire of ambition burning within us, "For 'tis ambition keeps honour bright, to do is better than to have done."

We have often thought that the American student of medicine had many advantages over students in foreign countries that perhaps he seldom realized. In the first place the cosmopolitan character of our people, composed of so many nationalities, tends to remove feelings of prejudice, which we find so prevalent in European countries; for instance, a Frenchman's attitude towards a German and vice versa.

Scarcely a generation ago, the course of study in our medical schools was so brief that many of our young physicians went abroad for further study, that they might receive inspiration from the masters in medicine; irrespective of whether they were French, English, German or Italian.

\*Read before the quarterly meeting of the Rhode Island Medical Society, Sept. 6th, 1923.

This receptive attitude of mind, namely, to be willing to receive information, no matter from whence the source, regardless of race or nationality, gave broader scope to American medicine, which has already borne fruit.

It now appears that America bids fair to be the greatest center of medical teaching in the world and may some day rival the great schools of ancient times, such as Alexandria, Salicet, Bologna, etc.

Yet, it seems to have been ordained that no race has a monopoly of the brains that produce clear thinking.

History reveals the story of the lives of eminent scientists, poets, warriors and statesmen distributed among all types of people and in all quarters of the globe.

The science of medicine is deeply indebted to Italian thinkers, for keeping alive the teachings of three noted Greeks, namely, Aristotle, Hippocrates and Galen, masters of the art of healing.

The first great modern medical school was at Salerno, where, beginning with the tenth, medicine was taught for four successive centuries. It is to Italy also we owe the conservation of medical classics.

Something worthy of emulation by physicians of our own time is taken from the writings of Ruggiero Rolando, written during the latter part of the twelfth century. He wrote: "We have resolved to write out, deliberately, our methods of operation, such as they have been derived from our own experience and that of our own colleagues and illustrious men."

The celebrated University of Bologna at one time had a student enrollment of 12,000 and the University of Padua 8,000. Pisa was also one of this triumvirate of renowned universities, the illustrious teachers of these schools attracted scholars from all parts of Europe. Vesalius, the noted pioneer in anatomy, a Frenchman, did most of his anatomical work at Bologna.

The great Harvey was a student at Padua and freely acknowledged the debt of gratitude he owed to his Italian masters. Eustachius, Fallopius, Varolius and Malpighi also pursued their studies in Italy. Virchow states that Morgagni, an Italian,

was the father of modern pathological anatomy and that his famous work, "The Seats and Causes of Disease," is worthy of study today by medical scholars.

Among some of the men who wrote clear descriptions of pathological conditions may be mentioned Montagnana of Padua, Savonarola of Ferrara, Arcolani of Bologna and Benedetti, who was professor of anatomy at Padua, Benivieni of Florence made dissections upon the cadaver with acute perception and accurate description; Malgaine says of him that "he wrote the only book on pathology which owes nothing to anyone."

Frascatorius wrote in 1546 his celebrated work called "De Contagione," in which his views coincide with the modern theory of infection by micro-organisms. Guy de Chauliac, called the prince of surgeons, made his studies in Italy and published *La Grande Chirurgie*.

We are all familiar with the name of Prof. Bassini of Padua, who developed an operation for the cure of inguinal hernia, which has been employed all over the civilized world.

The city of Genoa is about the size of Providence, and the principal part of it is situated high above the sea, which gives one a superb view of the blue Mediterranean and the low-lying mountains to the north. The dwellings, public buildings and stores compare favorably with any city of its size.

One of the finest hospitals in the world, named from its foundress, Duchess Galliers, we may visit here, and take with us many valuable ideas as to hospital location, size, construction and practicability.

I am told that this philanthropic woman, the Duchess de Galliers, contributed an amount the equal of two million dollars to this hospital.

The hospital is built on a hill facing the city; as you approach the building, you will observe that there are five pavilions, each two and one-half stories in height, with a high studded basement. All the buildings are connected by corridors. The front of the hospital, instead of being in a straight line, is in the form of a crescent.

The kitchen is situated at the rear of the main building, so that no odors from cooking permeate the hospital. The food is placed in heated receptacles, which are loaded on a flat car that runs on a track, when the car reaches the center pavilion, a turntable switches it either north or south to-

ward the four pavilions located on either side of the main building. Elevators take the food to the wards.

It seemed curious enough to see upon each enameled bedside stand, a supply of bread and a bottle of red wine which was the luncheon for the day. There are twenty-two beds in each ward, with special rooms at one end and a diet kitchen at the other end.

The operating rooms were especially attractive and unusual. A description of one may be of interest. Imagine an amphitheatre such as is usually found in hospitals, the arena of which, where operations take place, is completely surrounded with glass; the operator, his assistants and nurses, literally operate in a glass house. Visitors and students witness the operation through the glass protection; which prevents contamination of the atmosphere about the field of operation from the dust and bacteria which may be carried on the boots and clothing of the visitors. The surgery we witnessed was of a very high order and one case I recall that of a gastro jejunostomy performed dexterously, without the use of clamps.

The principal hospital at Florence dates from the thirteenth century, but one must remember that there are also modern buildings with every recent improvement adjoining the old building.

We witnessed Professor Berci perform two Bassini operations for inguinal hernia, the details of which were quickly and accurately carried out.

Milan impresses one as a large and busy modern city. Its famous Cathedral, ornamented with over a thousand statues, dominates the principal square.

An unusually large hospital, five centuries old, accommodates 3,000 patients. The oldest part of the hospital was originally a monastery and this building is in the form of a cross, thus making four large wards containing seventy beds each. The ceilings are thirty feet high, the window sills are seven feet from the floor and the windows reach nearly to the ceiling on both sides of these long wards, thus admitting plenty of fresh air, light and sunshine.

There is an altar at the intersection of the wards, which permits the patients occupying the beds of the four wards to participate in divine service. There are also seven modern pavilions, each containing four wards, and each ward thirty beds.

We shall next visit the eternal city, Rome, ever interesting because of its many monuments representing the life of past ages; the arch of Constantine, the Coliseum, the Pantheon, the Roman Forum, all of which recall the grandeur of the Roman empire. While there are several hospitals in Rome, the one most noteworthy and entirely modern is the Polyclinico, with more than 1,200 beds. This hospital might well serve as a model for hospitals in any country.

The grounds selected are extensive, which allows plenty of room for expansion. There is a central administration building, with four separate buildings, two and one-half stories high, on either side, connected by corridors. This arrangement permits the segregation of patients, so that we may have separate pavilions for medical, surgical, gynecological, orthopedic, pediatric and other specialties.

Professors Bastianelli, Allesandri, Durante, Ferrari and their assistants have charge of four surgical pavilions with four hundred beds. During one year over 3,500 operations were performed on the surgical services. There are at present some twenty-two buildings on the hospital grounds.

Professor Bastianelli, a tall, slight, vigorous man of perhaps fifty-five years, is undoubtedly one of the great masters of surgery in the world. I spent a delightful and instructive day with Prof. Bastianelli in his private hospital, situated near the Polyclinico. Sisters of the order of Franciscan Missionaries of Mary have charge of the hospital, including the nursing. Everything about the hospital is ideal. The technic of the operating room was particularly good. The chief assistant here, as in many places in Europe, are men in middle life. The younger physicians are second or third assistants. The sister in charge of the operating room was very efficient and gave evidence of having been in charge a long time.

I saw Professor Bastianelli, who speaks English, perform two operations, and then he showed me about the hospital. His laboratory was well equipped and he employed young women as technicians. One of the operations was done for the cure of a large ventral hernia in a very obese woman. He made a long, transverse, elliptical incision, and removed a great quantity of adipose tissue. The fascia was overlapped and the flaps sewed together with mattress sutures. Benzine

and iodine half strength U. S. P. or  $3\frac{1}{2}$  per cent, are used in preparing the skin previous to operating. The other patient had his leg amputated for gangrene, caused by diabetes.

Asepsis was carefully observed and the surgery was done with skill and precision. Next day, I spent with Professor Pestalozza at the Polyclinico, where he has charge of the gynaecological pavilion.

One of his assistants spoke English well, and explained many features of their methods. Professor Pestalozza operated for the cure of retroversion by a method I had never heard of. I wrote him on my return home, and he sent me a reprint describing his operation, which Dr. Corvese kindly translated for me. I have since added a method of shortening the round ligaments to be employed, in conjunction with Prof. Pestalozza's operation, which has proved effective.

We spent several days visiting hospitals in Naples, accompanied by Dr. Conca, who practiced in Providence for fifteen years.

One day we saw a surgeon about sixty-five years of age perform a Caesarian section in a deformed woman with kiphosis, narrow pelvis and also flexion and ankylosis of both hip joints. The surgeon wore white cotton gloves, he operated rapidly and within a minute had delivered a lovely baby boy. He made a transverse incision in the uterus, from one round ligament to the other. The wound in the uterus was closed with interrupted silk sutures. He was ably assisted by two surgeons, each one about twenty-seven years old, who were deeply interested and on the alert all of the time.

At another hospital, the Polyclinico, I saw some very excellent work done in the gynaecological pavilion, and made a visit to the wards and private rooms to see the results in cases previously operated upon. Some of the patients had their abdominal wounds dressed especially for us and all the wounds were healed by primary union.

With two of the resident surgeons, we examined about eight patients with abdominal masses, who were being treated previous to operation. There were cases of fibroids, ovarian cyst, salpingitis, etc. We noted with pleasure the completeness of the histories and the keen interest in their patients taken by these resident surgeons.

The hospital where Dr. Conca had served as an interne was very old and some of the wards con-

tained sixty beds. The operating rooms and a portion of the hospital were modern. We should bear in mind that many cases of elderly poor people are taken care of in the large wards of many of the old hospitals in Italy, where with us they are sent to an infirmary or poor house.

My stay in Naples was especially interesting and instructive, largely due to the kind offices of Dr. Conca. The hospitals of Italy are supported by grants from the central government and the city where the hospital is located, besides charitable bequests.

The University of Naples has about 3,000 students, and the University of Rome about 2,000.

I came away from Italy with the impression that the leading surgeons of Italy today compare favorably with the ablest surgeons of any country and are worthy of their ancient inheritance.

Remember that we can always learn something from the other man.

Contact with men who are masters in surgery, inspires one to higher ideals and stimulates one to work harder and, in consequence, do better surgery.

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#### INFLUENZAL GASTRO-DUODENITIS WITH JAUNDICE.\*

By A. M. BURGESS, M.D.

PROVIDENCE, R. I.

The term influenza is applied to an infectious disease or a group of related infections which has certain typical clinical manifestations. Of these, the headache, general aches and congestion of the mucous membranes of the upper respiratory tract are well known to the profession and laity alike—more especially because of the recent terrible experience of the whole world with the disease. The short course and the absence of leucocytosis are also characteristic. When the disease becomes pandemic in a virulent form, as in 1889 and 1918, it constitutes a very definite and easily recognized clinical entity. At other times the diagnosis cannot usually be made in such a positive fashion, as without the aid of a clear cut laboratory test the physician is forced to base his conclusions on his clinical examination only. To the mild cases such

terms as grippe and "grippy colds" are commonly applied and when bronchial or pulmonary infection takes place the anatomical terms, bronchitis and pneumonia, often suffice without mention of the etiological factor. Many borderline cases exist which may or may not be true influenza and in every instance the clinician is quite entitled to his own opinion, as a means of proof does not exist.

In forming a judgment regarding the numerous cases of influenza-like infections that have been occurring almost continuously since 1918, one must be guided by his own clinical impressions, and considerable difference of opinion undoubtedly exists. For example, only a few months ago the writer noted one morning—in the lay press—a statement by our most distinguished superintendent of health to the effect that there were no cases of influenza in Providence; this at a time when the writer was seeing on an average of about two new cases of what he considered influenza every day. These cases, it is true, were many of them mild, and all were without pulmonary involvement, but a large proportion of them had typical and at times very severe symptoms at the outset. Bronchitis was, however, fairly common. In those cases in which a leucocyte count was made it was invariably found to be normal or low. In a small proportion of instances a continuation of the fever and cough was associated with persistent and numerous moist rales usually heard over one lobe of one lung, ordinarily but not invariably a lower lobe. Occasionally the bronchial involvement appeared to be primary and the symptoms of nasal and sinus congestion were entirely absent, yet the low white count, the short course and early backache or headache suggested that the infection was to be classed as influenza. All standard text book descriptions of influenza allude to the gastro-intestinal type. About two years ago there was prevalent in this community and elsewhere in New England a type of acute gastro-enteritis associated with fever, often, but not always, headache and general aches, and a leucopenia to which this diagnosis could, it seems, reasonably be applied.

Let me state my own impressions of the whole situation as applied to Providence. It has seemed to me that since the pandemic of 1918-19 influenza has been constantly with us in a milder, less typical and constantly varying form. The cases in the pandemic were for the most part true to type,

\*Read before the Staff meeting of the Providence City Hospital, May 18th, 1923.

a most virulent infection with a marked tendency to pulmonary invasion. There appeared to be some immunity following the attack, as recurrences the same year were very rare and but a small proportion suffered a recurrence during the following year. During the next two or three years what appeared to be the same disease in a less virulent form was very common at times. Pneumonia was not very frequent. During the winter just past, influenza has, I believe, been of more frequent occurrence in this community than at any time since 1918-19, but it has been very mild. The infection at times has seemed to be limited to the upper respiratory passages, at times to the trachea and bronchi. The attacks have been short, but considerable debility has followed them. Recurrences have been very common, and even third attacks have occurred—suggesting that the disease has produced no lasting immunity. Furthermore, there has been a considerable increase in the occurrence of the type of complication which is the subject of this paper—gastro-duodenal infection.

During the past two years there have been reported throughout the country a large number of cases of mild contagious jaundice which at times has been of so frequent occurrence as to be called epidemic. (Blumer<sup>1</sup> has recently published a very interesting summary of the occurrence of this condition throughout the country. He, like most others who have studied this disease, is inclined to emphasize the jaundice as the main clinical feature, although he does refer to cases in which jaundice fails to appear. He also mentions the influenza-like initial symptoms. He was unable to find any evidence that organisms of the typhoid-colon group are a factor in producing this condition.) Tests of blood and urine have shown these not to be of spirochetal origin. As far as I am aware, no definite relation between these cases and influenza has been suggested, although I have heard them referred to by laymen as "flu jaundice." The cases mentioned in this communication are, I believe, of the same nature as those that have been observed and reported in the literature as above noted. In only one of the fifteen there is no record of an initial influenza-like attack and as this case was one of the earliest of the series it is probable, I believe, that the attack was not recorded because careful inquiry regarding it was omitted. All the fifteen were private patients treated in

their own homes, and the records are compiled from notes made in the course of a very exacting clinical practice and are not as complete as could be desired. (I am indebted to Dr. E. S. Wing and Dr. DeWolf, who attended him, for the record of his own case. I saw him but once at the height of his jaundice.)

Based on observation of the cases here recorded a description of the average attack is about as follows. After what appears to be a mild or moderately severe "grippe" the patient notices that his appetite does not return to normal. Instead there is a period of increasing anorexia, sometimes beginning two or three days later. This is associated, as a rule, with nausea and epigastric discomfort. Vomiting and true epigastric pain may be present and there is almost always distinct epigastric tenderness. After an interval of from seven to fourteen days, during which the symptoms usually have slightly increased, jaundice appears. As a rule, within a day or two of the appearance of the jaundice the symptoms abate and the patient gradually returns to normal. The jaundice varies from a very slight conjunctival tinge lasting a day or two to a fairly completely obstructive type which lasts for two or three weeks. In many cases splenic enlargement is noted. A number of patients have been observed but are not reported in whom the whole picture as outlined above, that is, initial attack, progressive nausea, epigastric tenderness and at times splenic enlargement has been noted, but in whom jaundice did not appear. In one or two of these a trace of bile was found in the urine. It is to be assumed that in these patients sufficient congestion of the duodenal mucosa to obstruct the outflow of bile did not occur.

TABLE I.

Maximum Temperature in Initial Attack	Influenza-like Symptoms	Day on which Jaundice appeared	Nausea and Anorexia (with vomiting = ++++)	Epigastric Tenderness	Leucocyte Count	Spleen Palpable	Days of Jaundice (approximate) Case No.
?	++	?	+++	0	—	++	12
101.2	++	8-10	++	Slight	1,666	—	14
103.4	++		+	+	—	—	—
?	++		+	?	—	—	—
?	Slight	8	+++	Slight	—	—	—
100.4	Slight	8	+++	Slight	—	—	—
102	++	10	++	0	8,450	++	10-14
100.4	Slight	4	Slight	0	—	—	—
100+	+++	6	—	?	—	—	10
102.8	+	5(+)	+	Slight	7,650	++	—
?	Slight	.9	Slight	?	—	—	—
?	+	?	++	0	4,500	0	10
103	++	4	+++	++++	9,950	0	10
?	+	15-17	++	++++	6,200	?	—
103	+++	5	++	+	8,500	0	—

<sup>1</sup>Blumer, G., Infectious Jaundice in the United States, J. A. M. A. 81:353, Aug. 4, 1923.

Table 1 graphically presents a comparison of the clinical data in the cases studied.

Case No. 13 is of interest because of the severity of the symptoms, the acute epigastric pain requiring morphia and the tenderness and muscular spasm suggesting a surgical condition in the upper abdomen.

Brief reports of cases No. 14 and No. 15 are given on account of the complicating conditions and the bacteriological findings.

Case No. 14. Dr. E. S. Wing, 38 years, physician.

Previous history irrelevant.

December 1, 1922, patient was taken with a mild attack of typical "grippe" which lasted four days. After he had been up and about six days he noted a cloudiness in his urine and found on examination that it contained an apparently pure culture of motile bacilli. This was followed by backache and fever and the appearance of pus in the urine. A sharp febrile attack of typical pyelitis occurred, lasting from about December 10th to December 27th. During the course of this attack there was marked anorexia and nausea and on December 17th jaundice appeared. A leucocyte count at this time was 8,500.

Cultures from the urine yielded a bacillus apparently identical with that found in case No. 15.

A second attack of fever lasting from January 2d to January 7th occurred, due to pyelitis on the other side. Recovery was uneventful.

Case No. 15. D. S. B., student, 19 years.

Seen January 25th, complaining of acute headache and backache. Has had chilly sensations all day. Temperature 102.6. Pulse 84. Throat, marked redness. Conjunctivae injected. Diagnosis, influenza. Next morning this patient's temperature was 101 and he complained of epigastric aching. Definite tenderness was present in epigastrium. That evening (Jan. 26th) the temperature rose to 103 and the patient complained of severe abdominal pain all over upper and lower abdomen. He was transferred to Jane Brown Me-

morial Hospital. Seen the following morning, the patient showed definite spasm of right rectus. Pain had localized chiefly in right lower quadrant, where there was distinct tenderness. Temperature 101. Pulse 80. Leucocyte count 6,200. Diagnosis, appendicitis, acute—complicating influenza. Operation by Dr. E. M. Porter, with removal of an acutely inflamed appendix with fibrin on its surface.

Cultures from the appendix on Endo's media yielded many colonies identified as *B. Coli* and many typhoid-like colonies. From these there was cultivated a motile gram negative bacillus which responded to all the cultural tests for *B. typhosus* but failed to agglutinate with a strong anti-typhoid serum. January 29th—two days after operation, and six days after the initial symptoms, jaundice appeared. Epigastric tenderness was present. Spleen was not palpable. The jaundice persisted for about ten days and recovery was uneventful.

Comment: This case is reported because of the appendiceal infection with low leucocyte count which, with the gastritis and duodenitis seemed to be an extension and continuation of the original influenzal infection. Cultivation of an organism of the typhoid-colon group apparently identical with that recovered in case No. 15 is interesting.

#### Summary.

The foregoing report deals with a mild infectious disease which on the basis of clinical conjecture can, I believe, properly be classed as a variant of the prevailing influenza. Although mild, cases 13, 14, 15 show that it may be fairly severe. The intercurrent pyelitis in case 15 and the acute appendicitis in case 14—both associated with an absence of leucocytosis at the height of the symptoms, suggest the possibility that the original infection had been transferred to the kidney pelvis (case 15) and the appendix (case 14) metastatically by way of the blood stream. Cultivation of an apparently identical organism from these two sources may be of interest.

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The R. I. Medico-Legal Society—Last Thursday—January, April, June and October. James B. Littlefield, Esq., President; Dr. Jacob S. Kelley, Secretary-Treasurer.

PAWTUCKET  
Meets the third Thursday in each month excepting July and August

STANLEY SPRAGUE	President	Pawtucket
GEORGE E. RONNE	Secretary	Pawtucket

PROVIDENCE  
Meets the first Monday in each month excepting July, August and September

WILLIAM B. CUTTS	President	Providence
P. P. CHASE	Secretary	Providence

WASHINGTON  
Meets the second Thursday in January, April, July and October

JOHN E. RUISI	President	Ashaway
W. M. A. HILLARD	Secretary	Westerly

WOONSOCKET  
Meets the second Thursday in each month excepting July and August

A. A. WEEDEN	President	Woonsocket
THOMAS S. FLYNN	Secretary	Woonsocket

## EDITORIALS

### THE RHODE ISLAND MEDICAL JOURNAL.

Some years ago, the date is of no consequence, the RHODE ISLAND MEDICAL JOURNAL supplanted and took over the affairs of the Providence Medical Journal, since which time the Rhode Island Medical Society has, through its Committee of Publication, administered its course.

Certain men, at the time of this conversion, of literary bent, decided that a broader scope could

be attained and a broader usefulness enjoyed by a state rather than a city publication and subsequent history has proven the justification of their decision and attitude. The trend of the JOURNAL has since been one of upward progress, if not in literary attainment, in substantial standing; it may be said that this result was not of spontaneous growth, however, but has been brought about because a certain small faction in the Rhode Island Medical Society had pride enough in and respect enough for the organization to work for and maintain this JOURNAL, that it might not perish, that the benefits derived from its publication, not

the least of which are our splendid exchanges—nearly fifty—with pausing to mention the dissemination of the Society news and many interesting medical subjects now discussed in its columns, should not be lost.

Being, therefore, a chattel of the Society, every member thereof should feel a paternal interest in the welfare of the JOURNAL; not entirely that it shall remain or be a self-sustaining publication; there are higher motives than that in the publishing of a medical journal, although its business affairs should be so conducted as to preclude the necessity of eleemosynary benefits, but principally that in its publication its motive should be the dissemination of literature of scientific value and medical interest, and of the state news as relating to our profession.

Every member of the Society is, therefore, in a way, responsible for the standing of the JOURNAL and its character; still more responsible are those more intimately connected with its publication; publishing even a small journal is a business enterprise and the responsibilities identified with it cannot be smiled away or ignored. To attempt the first is inane; the second exhibits a deliberate unwillingness, and in either, the good faith of the evader is, to say the least, susceptible to question. Personal convenience is of no significance in the discharging of an accepted obligation. It is achievement that counts.

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#### THE PSYCHIC IN LOCAL ANESTHESIA.

It is not very long since the attention of the medical profession was directed towards anesthesia and its relation to the surgeon and the patient. Present day literature is now flooded with writings on the subject and one almost asks the question, How much shall I believe? One surgeon does all of his surgery under local anesthesia, another very little if any. It is conceded that certain patients, those not of the too nervous type, are more suited than others for operations under local anesthesia. And it is equally true that it is more successful in some professional hands than in others. Is there a psychic effect? Do some surgeons possess personal qualities which inspire confidence and cause the patient to be good and not worry, etc., etc.? It is of course quite natural that certain qualities inspire confidence—witness the enormous popular-

ity of the charlatans and quacks. And it is also desirable that a physician be kind and sympathetic with his patients, but not too kind nor too sympathetic. And so it is with local anesthesia—the assurance that the surgeon will not hurt—and the fulfillment of this promise—this is the psychic element which is of the most avail. Now as to the advisability of the patient knowing about the operation and even seeing the field of operation. This may be a good thing, but we rather think not. Such an exhibition is only adding one more weight to an already over-burdened nervous system and serves no good purpose. Anesthesia varies with geographical localities. In the middle west gas oxygen and local anesthesia are used far more than in New England, and it might be thought perhaps we are rather behind the times. No one who has ever taken gas or gas oxygen will ever wish to take straight ether. Some of our local anesthetists, geographically speaking, have made national reputation by their use of gas before the ether, and given surgery an impetus the importance of which it is hardly possible to overestimate. In view of the large amount of work now being done elsewhere with gas oxygen, local anesthesia and the two combined, it is difficult to understand why these practices do not find more ready adoption and anesthesia given its proper attention and application.

Local application anesthesia has been of the greatest value in the development of dental surgery, and some dentists have acquired a skill in exodontia that is truly surprising. To inject a tooth without the patient feeling the insertion of the needle or the injection requires a knack that all operators have not acquired but brings fame and success to those who have. There can be no doubt but that in a short time local anesthesia will very largely supplant general anesthesia for exodontia.

For general abdominal work, we doubt if local anesthesia will ever supplant our usual methods. Those who have seen it used are not particularly impressed with its success, some of us would put it even more strongly. It is a wise surgeon who selects that method best suited to his case.

Most patients are quite sensible about accepting operation and going through with it. It is not often that they stipulate what anesthetic shall be used or show unwillingness to assist the surgeon and accept his advice. They have enough confi-

dence to submit to the operation and rarely question minor details. Meddlesome acquaintances make far more trouble than the patients themselves, both at the time of operation and during the after care. And so, as we have seen it, for a quarter of a century, the psychic stuff is resident largely in the minds of those who deal in that sort of fluff, who claim particular and peculiar insight into the human mind, whose diagnostic skill is uncanny in its precision and whose surgical dexterity makes them the only rational person to perform this or that particular operation.

Local anesthesia is a very valuable addition to the surgeon's work. It has a large but not universal application. It should be selected where practicable in those cases where general anesthesia is contraindicated or where it is not necessary. Combined with general anesthesia it is of great value in selected cases. It will never supplant general anesthesia except in a very few hands. Skill in its administration is very important, practice making the operator more successful in its use.

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#### PHYSICIANS AND PUBLIC HEALTH.

Most physicians have looked upon public health measures and public health laws with little favor. The exceptions to this attitude have been physicians who are engaged in public health work and a certain number of broad-minded physicians who have vision and have been interested in promoting improved health conditions. The opposition seems to be based upon the fear that public health measures will encroach upon the physicians' income by the treatment of more and more people by salaried physicians paid by public or private funds and by the increase of charity patients treated in hospitals. It is perhaps fair to say that some physicians hesitate to take an active interest in public health because of aversion to personal publicity. On the other hand, there are a large number who are so busy or lacking in interest that they do not inform or concern themselves with matters of public health.

This lack of interest on the part of the physician is to be deeply regretted, both from the standpoint of the physician himself and the public at large. The belief that the health department is taking bread and butter out of their mouths is not true. How many physicians stop to consider the

number of medical and surgical patients who are sent directly and indirectly to them each year? The health department is constantly telling school children to consult the family physician. It is true that some children are treated free when their parents could pay but will not. Why should the children suffer from neglect because the parents refuse to meet the expense? Where one case of this kind occurs many patients are sent to the doctor by the health authorities which would never have consulted him otherwise. One bit of present public health propaganda alone will greatly benefit physicians, namely, to get people to go to their doctor at least once a year for routine examination.

It is only within the last two or three years that the House of Delegates of the A. M. A. have taken any active interest in public health measures. Out of this interest only one good thing has resulted and that is the publication of a popular medical journal. There has never been any more important piece of constructive work if the public can be induced to read *Hygeia*. But there are many other things which the House of Delegates and each state society can do to help guide, either to encourage or discourage the enactment of public health laws and practices. On their part, they must, however, be broad-minded, far-seeing and not dominated by selfishness. Selfishness can never be laid at the door of the physician, until recently there has developed among a few men the possibilities of commercialized medicine, instigated largely by large surgical fees. The temptations of large surgical fees are leading many young men astray and creating great dissatisfaction among general practitioners. Such a spirit should be curbed by state medical societies, which should have active committees, both on public health matters and matters concerning the proper qualifications of general surgeons and surgeon specialties.

In the last analysis physicians must take care of all the sick whether rich or poor. Some of their work is a charitable contribution and his paid fees must make up for the time spent on patients too poor to pay. The doctor deserves a good income if he is capable. If there are enough physicians and a small enough amount of charitable work to be done, then each physician will not miss time spent on charity patients but will profit by doing his reasonable bit. On the other hand, if charitable work is too heavy, then some physicians should be paid for it.

The American doctor is faced with possibility of state medicine. It will avail little for him to rail against its coming unless he has a feasible and efficient plan which will provide good medical service to everybody, rich or poor. It is perhaps too late now to prevent something of the sort being brought about, for public health measures have caught the fancy of the laity and much legislation is being put through and will be put through whether the doctors like it or not.

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### ONE THING WE LACK.

Chief among the factors that keep Rhode Island "off the map" medically, that prevents the development of leaders in the profession and the recording of work of unusual and permanent value from our clinics, is the lack of teaching opportunities for our clinicians and laboratory workers. There is nothing that keeps a busy man so permanently "on his toes" as the association of a teacher with younger men who are ever alert and enthusiastic and as a rule so well informed that the instructor must constantly do his best in order to keep ahead of them. Successful teaching of the various clinical branches requires a large number of patients, "clinical material," as we sometimes almost inhumanly term it, such as is offered only in the wards and outdoor departments of the larger hospitals. Such teaching not only benefits the student and instructor but invariably raises the standard of work done in the hospital and the university. The successful medical school must be associated with large hospitals. The large hospital not associated with a medical school and in which teaching is not done suffers, its work is invariably of an inferior quality and the community suffers in consequence. This condition obtains in Rhode Island.

In New England, exclusive of Boston, there are well known medical schools, each a department of a university. In none of these communities are there hospitals as large or as rich in the variety of "clinical material" as are the hospitals of Providence. Many Providence clinicians have had the best of training and a number have had teaching experience. We have the hospitals, we have the men, we also have the University.

### THE MEDICAL PRACTITIONER AND THE AMERICAN SOCIETY FOR THE CONTROL OF CANCER.

By J. E. RUSH, M. D.

FIELD DIRECTOR AMERICAN SOCIETY FOR THE CONTROL OF CANCER.

Among the most important public health problems confronting the medical profession today is that of cancer control. It is possible to make a division of public health movements into several groups, depending on the amount of educational work which must be carried out before the program can be successful. In one group we find such diseases as typhoid fever, malaria and yellow fever, which may be controlled simply by educating a few individuals who possess the necessary power in a community to place the program in operation after they have been shown the desirability of such a procedure. This type of activity is relatively simple because it depends upon the education of a few individuals. Unfortunately, the diseases that can be controlled in this manner are among those which usually do not exact from the populace the greatest economic toll.

Another group of diseases may be effectively dealt with through police power and here again we depend on the education of a few members of any given community. For the most part the diseases which may be controlled by this means we refer to as "communicable" and usually they can be very effectively dealt with by placarding, isolation and quarantine.

There is another group of diseases which are not communicable and in which the education of but a few members of the community is not sufficient to affect the mortality rate. Here we find cancer, which depends for its ultimate control upon the education of every single adult of the community, with reference to the early signs and symptoms of the disease, for only in its early stages is cancer curable. With the present attitude of the public to seek medical advice only when they are aware of distressing symptoms, they must be told that early cancer is usually painless and that proper treatment cannot be instituted until they have sought the advice of a physician.

The medical profession is interested in all types of medicine whether preventive or curative. As a matter of fact, there really is no hard and fast

line of demarcation between preventive and curative procedures any more than there is a dividing line between the metals and the non-metals. The medical profession is interested in all problems of public welfare but when it comes to matters concerning public health they are the only ones who through tradition and training are capable of handling the problems which present themselves for solution. It is the only profession at the present time that is engaged in real preventive medicine and it is the profession of election for this type of work. Usually public health movements have been initiated by the medical profession but in many instances the work has passed into the hands of the laity because the members of the medical profession have been preoccupied with other important problems.

What we have said with regard to the attitude of the medical profession towards public health work clearly emphasizes the need of control by the medical profession of all public health movements. The profession is particularly interested in the problem of cancer control not only because it is of great humanitarian interest but because of the further fact that cancer is one of those conditions in which it has been clearly demonstrated that the medical profession is the only one capable of offering a solution. While sanitary engineers, epidemiologists and others may be of great value in the conduct of specific public health movements, their training and experience does not make them capable of helping in cancer control. The slogan of the American Society for the Control of Cancer, that "Early cancer is curable if you will consult your medical practitioner in time," again clearly emphasizes that the physician is the only one capable of reducing the mortality from cancer.

Another interesting feature of the movement for cancer control is that the establishment of diagnostic clinics during National Cancer Week is of some educational value to certain members of the medical fraternity because important points of differential diagnosis between early carcinoma of tongue, for example, and primary luetic ulcer, are demonstrated. The cancer movement in this respect is one of the few that attempts to repay the physician for the great effort he has expended in its behalf.

It has been claimed by some of the unthinking individuals among the laity that preventive and

curative medicine are diametrically opposed. They do not realize that there is, in the last analysis, but little difference between preventive and curative measures. For example, all physicians take blood pressures and make urine analyses during the course of a pregnancy and not by the wildest stretch of the imagination can this be interpreted as a curative measure—it is a preventive measure pure and simple.

Through various educational movements which are now being conducted to instruct the public with regard to conditions which are definitely preventable, the great mass of the people are gradually coming to realize that the physician must be looked upon as a teacher and advisor rather than one who is to be consulted only when symptoms of a diseased condition have manifested themselves. The physician, too, realizes that this teaching attitude is appreciated by the public, for by this means he is able to prevent premature deaths among his clientele. Not only does he spare the patient in question for future usefulness, but, more important, he does not divorce the rest of the members of that particular family. The physician realizes that the most appreciative patient is one who, through early advice and proper instruction, has been saved from untold suffering and an untimely death.

All health movements if properly managed and ethically controlled by the medical profession will not only eliminate certain objectionable features present in some of them as now conducted by the laity (who have no appreciation of medical ethics) but such activities will help consolidate the medical profession against the ever increasing influence of the cults. It is true, that we as a profession, do not heartily approve of certain public health movements now in progress, because they do not conform to our ethical code. If they were controlled by the medical profession this objection would be removed.

It must be realized that the cults never would have existed had the medical profession taken a definite stand against them, but realizing that "Imitation is the sincerest flattery," we have allowed them to go on, to exploit the public until even the great mass of the people has recognized the lack of sincerity which prompted the various movements.

The proper extension of these ideas relative to organization in order to control public health prob-

lems contains within it the answer to the proponents of that most preposterous type of activity known as "State Medicine."

The organization for cancer control is dependent upon the activities of the medical profession; and therefore the units upon which the organization is built are the State and County Medical Societies. The whole movement has been endorsed and approved by practically all national, sectional, state and local medical and surgical bodies, because it is entirely controlled by the profession itself. In the perfected organization for cancer control, we have the ground work to handle other problems of a public health nature; be they ones already in existence or future ventures. By proper organization, too, we shall be in a stronger position to abort detrimental legislation, whether directed at us or to legalize the ignorant cults. A public health problem directed solely by physicians will do more to properly organize the medical profession than any other type of activity.

It has been pointed out that if we do not seriously consider the "scientific attainments" of the cults, then every preventable death is a reflection on us. It has been claimed that the fact that the patient did not come early enough to us for examination and advice is no excuse; that we, as the only logical profession engaged in the practice of the healing art should have the undivided confidence of the public to such an extent that they will report to us what are very trivial matters and thus give us opportunity to institute proper procedures in time. In the vernacular of the street, it has been suggested that we should "sell ourselves to the public"; which, in other words, means that there is at the present time a great need of ethical publicity on the part of the profession. It really seems that this would, to a very great extent, increase our usefulness to the community in which we practice. If this is true, then no physician can be so busy that he cannot devote a small amount of time to help in the campaign for cancer education, because by so helping, he is not only advancing his own usefulness to his community but is of the greatest value to his medical brothers and to his profession.

A few members of the laity have explained what they have interpreted as apathy on the part of certain of the medical profession toward preventive medicine, by emphasizing the fact that preventive medicine was diametrically opposed to curative

measures. We of the medical profession realize the fallacy of this. Let us consider an analogy from the field of engineering. Suppose that ten engineers were bidding on a contract to construct a road between two adjacent cities. Only one could be successful; but would the others put obstacles in the way to prevent him from completing his task? The answer is apparent. They would not; for they would realize that when the public had seen the value of this road, they would demand similar ones in all other directions and hence the other engineers would have an opportunity to build some of them. I realize that the above example compares a business conducted purely for monetary return, to a profession which interests itself chiefly with humanitarian efforts, but the very few of the public who believe that all persons are actuated by ulterior motives should be answered. The good roads analogy applies directly to medicine, for the medical practitioner realizes that each time the public is convinced that it is unnecessary for them to suffer with various ailments they demand the removal of others which heretofore they patiently tolerated. An example may illustrate this point:

A friend of mine who for many years was almost an invalid from recurrent attacks of what was then diagnosed as "inflammation of the bowel" and for which, at that time there was no known cure, was simply forced to allow the condition to exist which undermined his health and lowered his efficiency. At the present time because of the knowledge of the laity concerning chronic appendicitis he would know that an operation requiring him to be at a hospital for but two short weeks would give him complete relief and enable him to resume his life's work at a greatly increased efficiency.

Our medical ethics instituted at the time of Hippocrates admit of no change; but our interpretation of them may be broadened to meet the changing conditions; especially those which have been brought about during the past two or three decades. It may be necessary to change our ideas regarding proper non-personal publicity for the medical profession as a whole and for our state and county societies. In this connection I am reminded of the story of the young color-bearer at Gettysburg who had advanced somewhat ahead of the lines, and when ordered back to his position by his commanding officer replied, "Bring the line up to the flag."

## CASE REPORTS

### *Two Cases of Anthrax.*

C. C. DUSTIN, M.D. R. S. BUOL, M.D.

PROVIDENCE CITY HOSPITAL.

#### Case No. 1.

On July 24th a male white butcher of 57 years disposed of the carcass of a cow that died from splenic fever or anthrax. No precautions to protect the hands were taken. On July 27th he noticed a small vesicle on the dorsal surface of the right hand over the fleshy portion between the first and second metacarpal bones. Three days later this small vesicle had increased in size and the hand began to swell. The patient was seen by a surgeon, who found large Gram positive bacilli growing in long chains. A diagnosis of malignant pustule was made and the patient was sent to the Providence City Hospital. Here the laboratory findings were confirmed. The lesion was about 2.5 cm. in diameter with a great deal of edema of the hand and wrist. The central portion of the lesion was covered by a leathery black crust and this was surrounded by a ring of vesicles, some of which had been broken. A great deal of sero-sanguinous exudate was being discharged.

The physical examination was negative and the temperature, pulse and respirations were normal. The hand caused very little discomfort. On the following day after sensitization tests anti-anthrax serum was given, 50 cc. intravenously, 40 cc. intramuscularly, and 10 cc. were injected at 3 points about the lesion. Local hot dressings of boric acid solution were applied. Twelve hours after the first serum was given the hand and wrist were considerably more edematous and a band of lymphangitis extended from the wrist to the axilla along the medial aspect of the arm. The axillary lymph glands were enlarged and tender. The temperature was 98.6 F.

Fifty cc. of anti-anthrax were given intramuscularly and as there was considerable local pain all the other serum treatments were given intravenously. Every 12 hours 50 cc. of anti-anthrax serum were given intravenously until 250 cc. had been given, making a total of 400 cc. given. After the third day in the hospital the lymphangitis and local edema began to subside and the lesion gradually healed. No reaction from the serum was

experienced other than a moderately severe urticaria which appeared five days after the last intravenous treatment. This responded readily to the subcutaneous injection of 1 cc. of 1-1000 adrenalin. The patient was discharged well on the 30th day after admission.

#### Case No. 2.

This patient, age 28, is the son of patient No. 1, and autopsied cattle with splenic fever the same time as case No. 1.

September 22nd, 1923, the patient noticed a bright red papule on the flexor surface of each wrist. The following day a physician burnt these with carbolic acid, but the lesions soon became more active in appearance, and the patient came to the City Hospital four days after the onset.

The patient on admission complained of fever for the past three days and headache of one day's duration. Temperature, pulse and respiration were normal. Physical examination was negative except for the local condition. The lesion on the left wrist was a dusky red papule about 1.5 cm. in diameter with a central eschar covered with a sero-sanguinous discharge and surrounded by an area of swelling and erythema that was not painful to pressure. Direct smears were taken from this lesion and a stab culture into veal infusion agar was made. The lesion on the right wrist was a vesicle upon a base about .5 cm. in diameter with a dark center, and had no erythema about it.

September 26th, 1923, the day of admission, the patient was given 50 cc. of anti-anthrax serum intravenously, 40 cc. intramuscularly and 10 cc. subcutaneously at 3 points about the lesion on the left arm. There was a band of lymphangitis extending from this lesion to the elbow. Hot bicarbonate dressings 1-10,000 were applied locally to both wrists and have been continued. A few hours after the serum had been given the temperature went to 102, pulse 98, respirations 30—probably due to serum reaction.

September 27th the left arm was swollen and edematous. The lesion of the right wrist showed little change, temperature 100, pulse 95, respiration 25. Fifty cc. of anti-anthrax was given intramuscularly and 50 cc. intravenously, none given subcutaneously.

September 28th, temperature, pulse and respiration were normal and have remained so. Inflammation about the lesion of the left wrist sub-

siding. Patient very comfortable, with no complaints.

On September 29th and 30th, 50 cc. of anti-anthrax serum were given intravenously. Intramuscular injections were discontinued because of pain caused by the two previous injections.

October 2nd, all signs of inflammation on the left forearm gone. Lesions on both wrists shrinking in size.

October 4th a serum rash appeared on body—eight days after the first serum was given. This caused no discomfort and no rise in temperature.

October 5th the patient was allowed up and the next day allowed out of doors.

October 12th: The lesions are markedly reduced in size but the central eschar still persists and is firmly attached by a pedicle. Patient is waiting for this eschar to work off before discharge.

Bacteriology. The smears taken on admission showed large, square ended, Gram positive bacilli singly and in chains. The stab culture showed the same organism and streptococci.

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## TWO CASES OF VAGINITIS CAUSED BY FOREIGN BODY.

I. H. NOYES, M.D.

(From the Gynecological Service of the Providence City Hospital.)

### Case 1.

A girl, 10 years old, was brought to the hospital in June, 1923, because of a profuse vaginal discharge. She had been "boarded out" for three years until seven weeks prior to admission, when she was removed to the home of a relative.

The story related by the patient was that she had frequently been assaulted by a man in the house where she lived. In view of this and the profuse discharge, it was thought on admission that the child might have gonorrhea. A stained smear was reported "suspicious" and appropriate treatment was ordered by the interne.

Examination a few days later showed some purulent discharge about the vulva and inflammation of the mucous surfaces surrounding the introitus. On inspection of the vaginal orifice, a dark object was noticed in the upper anterior portion of the vagina. When grasped, this proved to be the end of a safety-pin which measured one-

half by two inches and, from its appearance, had been in the vagina for at least several weeks.

Further treatment was omitted except for external cleansing and dusting with boric acid. The discharge disappeared entirely during the next few days and did not return, though the child was under observation for a number of weeks.

She persistently denied any knowledge as to when or how the safety-pin was placed in the vagina.

### Case 2.

A girl, aged 15, was referred to the Out-patients' Clinic in August, 1923, because of a profuse foul vaginal discharge of two weeks' duration. She claimed to have been assaulted by her step-father some two years before. Later she developed signs of secondary syphilis and received treatment in another department of the hospital.

Examination of the external genitals showed no evidence of infection of Skene's or Bartholin's glands. Upon introducing a speculum into the vagina, a grayish object was noticed in the vault. This was grasped and removed, when another similar mass was seen. Each was soft and covered with a foul discharge and, when more closely inspected, was found to be a wad of toilet paper.

The cervix and vaginal vault were reddened and bled easily when sponged. Stained smears taken from urethra and cervix were negative for gonococci and within a week all evidence of vaginitis had disappeared.

No credible story could be obtained as to when or why this material had been introduced into the vagina.

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## INTERESTING CASE

L. L. ALBERT, M.D.  
CENTRAL FALLS, R. I.

One of the most interesting phases of modern life, rarely met in the United States, but common in Portugal and in the Cape Verde Islands, is the problem presented by the intermarriage of black and white. The offspring may be pure white, African black, or mulatto.

With the great influx of immigration to Rhode Island from the Cape Verde Islands came this problem.

The writer has an extensive practice among immigrants from this territory and in his practice

has witnessed many unusual results of intermarriage, but the most remarkable case came to his attention a short while ago in Pawtucket. A white Portuguese woman married a colored Brava, who came from the Cape Verde Islands. Their first offspring was a boy, who was a pronounced blonde. It is, however, the second pregnancy that produced the unusual case. The woman bore twins, a girl and a boy. The girl, who was born first, is a blonde, while the boy is black.

Multiple pregnancy may arise from one or more ova in a single uterus, from two or more ova impregnated in a double uterus or from one ova or more in the uterus and one extra-uterine.

In this case, we have a case of superfecundation, where there is an impregnation of one ovule after one has been already impregnated, or the fertilization of one ova of the same ovulation at a second coitus after one has been already fecundated.

In superfecundation, the children may or may not differ, and two children born at the same time may differ. It may also happen as a result of superfecundation that twins born with different physical peculiarities may have different fathers.

What the true state of facts in the aforesaid case that led to the superfecundation is, will remain a mystery, but the solution of it would be interesting.

## SOCIETIES

### RHODE ISLAND STATE MEDICAL SOCIETY

The regular quarterly meeting of the Rhode Island Medical Society was held at the Medical Library, Providence, Sept. 6th, 1923, at 4 P. M., the President, Dr. Arthur T. Jones, presiding.

The minutes of the preceding meeting were read by the Secretary, and approved.

The program was as follows:

1. "Modern Italian Surgery," by Dr. John W. Keefe, Providence. This paper was based upon the author's recent trip to the hospitals of Italy, and recounted in an interesting and entertaining vein the degree of skill shown by the past and present Italian school of surgery; a description of many of the hospitals and interesting anecdotes concerning several well known Italian operators.

Discussion of the paper was made by Drs. Corvese, Chapman, Brown and Ventrone.

2. "The Clinical Application of Some New Phases in Endometrial Pathology," by Dr. Arnold Sturmdorf, New York. The essayist stressed the newer conception of the function and physiology of the endometrium and especially the role played by the lymphatics in the extension of infections from the lower to the upper genital tracts. Discussion of the paper was made by Drs. Hussey, Noyes, McCann, Jones and Keefe.

After adjournment a collation was served.

J. W. LEECH, M.D., *Secretary*

### PROVIDENCE MEDICAL ASSOCIATION.

The regular monthly meeting of the Providence Medical Association was held at the Medical Library, 106 Francis Street, Monday evening, October 1, 1923, at 8:45 o'clock, with the following program: Three cases of fracture of the forearm treated by open reduction, Dr. A. A. Barrows. Discussion was opened by Dr. Roland Hammond. Tuberculous glands of the neck, Dr. F. G. Hussey.

The Standing Committee approved the applications of the following men: Dr. John H. Brothers, Dr. Francis B. Sargent, Dr. Henry McCusker, Dr. Earl A. Bowen, Dr. George W. Waterman, Dr. Charles H. Gannon, Dr. Maurice Adelman, Dr. Owen L. Murphy. Collation followed.

DR. PETER PINEO CHASE, *Secretary*

### R. I. OPHTHALMOLOGICAL AND OTOLOGICAL SOCIETY.

The annual meeting of the R. I. O. & O. Society was held at the Wannamoisett Country Club Wednesday, Sept. 26, 1923, the Society being the guests of retiring President, Dr. Howard E. Blanchard.

At 6:30 P. M. the members present sat down to a delightful chicken dinner, "a la Wannamoisett," which was certainly enjoyed by all.

To Dr. Blanchard a rising vote of thanks was extended for his very cordial hospitality.

The annual election of officers followed the dinner and the following officers were unanimously elected for the ensuing year: President, Dr.

Nolton Bigelow; Vice-President, Dr. Frank M. Adams; Secretary and Treasurer, Dr. Jeffrey J. Walsh.

The minutes of the previous meeting were read and accepted.

Under new business, it was voted to pay the usual twenty-five dollars to the R. I. Medical Library Building Fund and to buy the usual eye, ear, nose and throat journals for the Medical Library.

Motion moved and seconded that chair appoint a committee of three members to consider the advisability of making recommendations to the State Board of Public Roads, regarding a visual acuity test for automobile operators, with authority to act if occasion arises, and to report back to the Society at the next meeting.

Moved and seconded that the Secretary be appointed a member ex-officio of this committee, which comprises the following members: Dr. F. J. McCabe, Dr. J. F. Hawkins, Dr. W. C. Laughlin.

Meeting adjourned at 8:30 P. M., the next meeting to be held at the call of the President.

JEFFREY J. WALSH, *Secretary.*

## HOSPITALS

The regular monthly meeting of the Memorial Hospital Staff was held on October 2, 1923, with a large attendance present.

A demonstration of a lung motor was given by Mr. Frey, through the courtesy of the Blackstone Valley Gas & Electric Company, showing how the lung motor will take the place of the pulmotor. There was a discussion by Dr. Arthur T. Jones, Providence, R. I.

JOHN F. KENNEY, M.D., *Secretary*

## NOTES

A ready, not to say eager, response was evidenced by the members of the Rhode Island Medical Society upon the receipt of the following:

"The President of the Rhode Island Medical Society extends to you a cordial invitation to be present at the Medical Library building on Saturday evening, September twenty-second, at eight forty-five o'clock.

"Dr. Robert Emmett Farr of Minneapolis will present a paper on 'Surgery Under Local Anesthesia' and show motion pictures of major surgical operations.

"Dr. Farr stands pre-eminent in America in the development of local anesthesia, and his book on this subject, recently published, is a masterpiece."

The meeting was largely attended and the various schemae and pictures so graphically shown was conclusive demonstration of what may be done by one who has the temerity and aggressiveness to evolve his convictions. We congratulate Dr. Farr. We may also emphasize the fact that the Society should feel indebted to Dr. Jones for the instructive pleasure he has given us.

## MISCELLANEOUS

### FAULTY FOOD IN RELATION TO GASTRO-INTESTINAL DISORDER.

The thesis is propounded by Robert McCarrison, London, England (*Journal A. M. A.*), that much of the gastro-intestinal disorder of civilized peoples of the present day is due to faulty food. He presents evidence of the incidence of such disorder among civilized communities and of its comparative absence among certain races living under more natural conditions; and contrasts, in general terms, the food habits of the former with those of the latter. He refers to the special relation of perfect food to the functional perfection of the gastro-intestinal tract; and from these sources advances presumptive evidence of the effects of faulty food in impairing the functional perfection of the digestive system. Experimental evidence of these effects is given, and attention directed to the applicability of the experimental results to the genesis of certain acute and chronic gastro-intestinal disorders. McCarrison asserts that faulty foods capable of causing similar effects in man to those produced experimentally in animals are widely made use of at the present day. In guarding the national health, McCarrison says physicians have three obvious duties; the first, to instruct the masses as to what to eat and why they eat it; the second, to apply the results of science to the production of natural foods in abundance and to their widespread and cheap distribution, rather than to the erection of institutions for the treatment of maladies due to their want; the third, and most important, ardently to pursue investigations and the acquirement of knowledge.